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INNOVATION PROFILE

Early Results Show WellPoint's Patient-Centered Medical Home Pilots Have Met Some Goals For Costs, Utilization, And Quality

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ABSTRACT Primary care must be reengineered to improve outcomes and affordability. To achieve those goals, WellPoint invested in ten patient-centered medical home pilots that encourage care coordination, preventive care, and shared decision making. Two of the three pilots described in this article—in Colorado and New Hampshire—layer incentive payments for care coordination and quality improvement on top of a traditional fee-for-service payment. The third—in New York—pays doctors an enhanced fee that is tied to achievement of quality levels. Preliminary evaluations show encouraging signs that the Colorado and New Hampshire pilots are meeting some cost, utilization, and quality objectives. A full evaluation in all three states is ongoing. To help enable systemwide transformation, WellPoint is now applying similar payment strategies to primary care practices that may not have the resources to become full-fledged medical homes.

Primary care essentially is designed to encourage health and wellness, provide an initial level of medical care to the individual patient and his or her family, and ensure that appropriate specialist care is delivered. All of these elements are central components of high-quality, cost-effective health care. But today most primary care physicians are not compensated for important elements of care, such as coordinating care among specialists and other providers and providing access outside of normal business hours.

The patient-centered medical home redesigns primary care reimbursements to reward physicians for aspects of care that are most important to good patient outcomes. In patient-centered medical homes, for instance, additional payments are given to physicians to support care coordination and preventive activities that improve the health of patients.

To demonstrate the benefits of this model, WellPoint engaged in ten patient-centered medical home pilots. The three described in this article provide enhanced payments to primary care physicians through a blended payment model.

In Colorado and New Hampshire, WellPoint's affiliated health plans paid physicians fees based on services provided, then distributed monthly care management payments to support comprehensive services to meet patient needs. In addition, physicians who met certain utilization and quality targets were eligible for a pay-for-performance bonus.

In New York, WellPoint's affiliated health plan implemented an enhanced fee-for-service initiative that provides physicians with reimbursement in addition to standard fee-for-service payments to encourage quality-improvement measures such as care coordination and preventive care.

Each pilot program shares the goal of trans-

forming primary care through innovative payments that encourage delivery of the high-value care that is critical for improved health.

The Importance Of Primary Care

The importance of primary care to improved health was recognized in the 1960s when a report from the American Medical Association's Ad Hoc Committee on Education for Family Practice and a Council Report on Education for Family Practice advocated for a focus on general practice.[1] In 1994 the Institute of Medicine promoted primary care as "the provision of integrated, accessible health care services by physicians who are accountable for addressing a large majority of personal health care needs."[2]

However, primary care is facing increasing challenges. For example, there is a shortage of primary care physicians.[3] This problem results from a number of factors, including insufficient reimbursement, long hours, a perceived lack of respect from key stakeholders in the health care system, and the difficulty of delivering holistic care in today's fragmented delivery system.

WellPoint's Patient-Centered Medical Homes

In 2006 several large national employers worked with primary care medical societies and health plans to form the Patient-Centered Primary Care Collaborative, a nonpartisan forum dedicated to improving patient-physician relations and to making care delivery more efficient and comprehensive.[4] The collaborative played an important role in convening stakeholders to define capabilities and share best practices and tools to help physicians transform their practices into medical homes.[5,6] WellPoint was a founding member of the collaborative and remains on its leadership team.

As a result of its strong market position, WellPoint was well positioned to play an essential role in revitalizing primary care. Through its affiliated health plans, WellPoint serves thirty-four million members, or one in nine Americans. It is a Blue Cross or Blue Cross and Blue Shield licensed plan in fourteen states. Many of the medical home locations selected by WellPoint plans were fertile environments for change—places with a history of collaboration between payers and physicians as well as the presence of a local convening organization.

Wellpoint began its investment in patient-centered medical homes in 2007, and its plans have been engaged in ten patient-centered medical home pilots in Colorado, Connecticut, Maine, New Hampshire, New York, and Ohio that include both health plan members affiliated with WellPoint and patients enrolled in other plans. The pilots have served 134,000 WellPoint-affiliated health plan members and 255,000 participants across all payers, inclusive of WellPoint membership.

Early, non-risk-adjusted results from three pilots show improved measures of quality for chronic medical conditions, greater use of preventive services, and cost savings. These were the first pilots to have been analyzed; results from the others are forthcoming. Although these results are preliminary, they have provided the foundation for the payment and structural changes that WellPoint is making throughout its affiliate network to drive improved clinical outcomes and control rising medical costs.

In the pilots, each patient has a relationship with a primary care physician who is focused on providing continuous, comprehensive, and coordinated care based on the patient's individual needs. Care is provided in a manner that ensures access, fosters shared decision making between the physician and the patient and the patient's caregivers, and promotes wellness and prevention.

To support this model, WellPoint plans provided primary care physicians with resources—including shared patient claims information—to enable better treatment in line with evidence-based guidelines that promote an individualized, whole-patient approach to care delivery. In this article we highlight key elements and results from the pilots in Colorado, New Hampshire, and New York.

COLORADO WellPoint was one of the founding members of the Colorado Multipayer Patient-Centered Medical Home Pilot, which was launched in May 2009 and is further described in this issue of *Health Affairs*.[7] The convening organization was the Colorado Clinical Guidelines Collaborative, a nonprofit, multistakeholder collaborative now known as HealthTeamWorks that is working to promote integrated care based on evidence-based medicine.

The Colorado pilot was one of the first in the nation to be formed when health plans voluntarily came together to support the transformation of primary care. Joining in the effort were health plans,[8] employers, employer groups,[9] physician medical societies,[10] and independent practice associations.[11] Sixteen physician practices, representing a total of sixty physicians, participated in the pilot. The practice transformation and external evaluation were funded in part by the Colorado Trust and the Commonwealth Fund.

There were 100,000 patients receiving care in the medical home pilot. Of those, 20,000 had

commercial insurance, and most of them were fully insured. The remaining 80,000 patients were covered by Medicaid, Medicare, or employer self-insurance. Of the 20,000 commercially insured patients, 6,200 were members of WellPoint's affiliated health plan in Colorado.

The WellPoint plan paid both fee-for-service, in the form of a baseline payment for services provided by the physician, and pay-for-performance, with a care coordination fee and a payment based on the achievement of quality and cost or utilization measures. The convening organization received grant funding to pay for practices to apply for the National Committee for Quality Assurance medical home recognition and helped practices improve their ability to function as medical homes.

The WellPoint plan paid additional quality-based reimbursements to participating practices twice a year. Practices could earn level 1, 2, or 3 recognition from the National Committee for Quality Assurance based on their record of delivering various elements of care. Practices that earned level 3 recognition, the highest level, earned an extra $7.50 per patient per month from the WellPoint plan.[12] Fourteen of sixteen practices earned this highest level of recognition. The other two practices achieved level 2 recognition and received additional monthly payments of $6 per patient.

In addition, beginning in the second year, WellPoint included a pay-for-performance payment based on quality and efficiency measures such as improving care for chronic illness, encouraging appropriate emergency department use, and reducing unnecessary hospitalizations. The first performance payment was based entirely on quality improvement, with the amount hinging on the degree of improvement in the quality measures. The second performance payment, for the third year, will be based on both quality and cost efficiency, but the formula has not yet been finalized.

NEW HAMPSHIRE Similar to the Colorado medical home pilot, the New Hampshire Citizens Health Initiative Multi-Stakeholder Medical Home Pilot is a multipayer demonstration. In this case, the foundational payment is fee-for-service with an added care coordination fee. WellPoint and some—but not all—of the other payers added a performance-based payment.

The nonprofit New Hampshire Citizens Health Initiative and participating payers designed the pilot, set performance measures, and ultimately selected nine practices comprising seventy-five physicians to participate. The nine practices were geographically dispersed and included both private and hospital-owned practices as well as a community health center. Each practice was required to have National Committee for Quality Assurance medical home recognition and open access for patients, which meant either flexible scheduling or extended hours.

The 30,000 patients participating in the pilot were covered by four commercial insurance companies. WellPoint fully insured 10,000 of them.

Payments to the pilot sites started July 1, 2009. The patient-centered medical home demonstration was to conclude June 30, 2011, but it was extended six months to obtain additional data to enable comparisons between it and practices not in the pilot.

Each participating health plan in the New Hampshire pilot received a per patient per month care coordination payment on top of a fee-for-service reimbursement. Each insurer set its own payment amounts and paid physicians twice a year, based on the number of patients attributed to that physician. The average care management payment was $4 (the WellPoint payments were $2, $4, or $6 for practices with level 1, 2, or 3 recognition, respectively).

Standard quality data, aligned with each plan's existing quality programs, were collected for diabetes, congestive heart failure, and cardiovascular disease. See the online Appendix for examples of the quality metrics.[13]

The WellPoint-affiliated health plan rewarded high-performing physicians by increasing payments for subsequent years. Practices could receive a 2 percent, 4 percent, or 6 percent increase in their evaluation and management payments. Representatives of participating practices met monthly to share their experiences with office process flow and their challenges and successes.

NEW YORK WellPoint's New York patient-centered medical home is much different from the Colorado and New Hampshire models: It is a single health plan model, and it pays doctors an "enhanced" fee pegged to the achievement of quality levels.

The program originated, in part, from the New York City Department of Health's Primary Care Information Project. In that project, the department began placing electronic health record systems in selected primary care physician offices in 2008. The goal was to improve care in underserved communities through health information technology.

Initially, to be eligible, physicians had to have a 30 percent Medicaid patient volume; this threshold was later reduced to 10 percent. To participate, practices had to commit to following patient-centered principles of care. Under the project, the department agreed to pay the software licensing fees for eligible practices, provide on-site training and tools, and help practices obtain National Committee for Quality Assur-

ance recognition.[14]

Seeing a unique opportunity to test the patient-centered medical home concept in diverse populations and clinical settings, WellPoint announced in 2009 that it would begin building a patient-centered medical home around physicians participating in the primary care information project. Most of the physicians worked in federally qualified health centers and small physician practices serving low-income patients. For the pilot, WellPoint also included a broader group of primary care physicians participating in its network, including independently practicing physicians serving affluent populations and physicians practicing in academic medical centers.

"Enhanced" fee-for-service payments resulted in payments that were roughly equivalent to $3 per patient per month for practices that achieved level 1 recognition, $5 for those with level 2 recognition, and $7 for those with level 3 recognition.

Study Data And Methods

The Colorado pilot was evaluated by WellPoint and a researcher from the Harvard School of Public Health, and the New Hampshire pilot was evaluated by WellPoint and a group from the Heller School for Social Policy and Management at Brandeis University. In each case, WellPoint performed a "pre-post" analysis, measuring the pilot population's utilization and cost trends from a base period before implementation through the period after implementation against a control population's experience over the same time period.

WellPoint used claims data that included physician, hospital, and other professional services. Primary metrics included utilization rates for hospital admissions, emergency department visits, office visits, and antibiotic usage.

HealthCore, WellPoint's health outcomes subsidiary, conducted a baseline analysis of the New York pilot using insurance claims data from WellPoint's affiliated health plan in New York. HealthCore used claims data from 2007–08 to identify enrollees of the medical home practices and a control group composed of enrollees who were not medical home patients but who received care from primary care providers in the same ZIP codes.[15]

The pilot ran from August 2010 to July 2012, and final data have not yet been analyzed. However, the baseline data are available. They are relevant here because the pilot included only early adopters who had already made many of the changes necessary to transform their practices before the start of the pilot—in many cases including achieving National Committee for Quality Assurance recognition and implementing electronic health record systems. Thus, the fact that these practices performed better than the control group supports the belief that practices that adopt patient-centered principles of care provide care that is higher quality and more cost effective than that provided by other primary care practices.

The baseline analysis included 31,032 patients treated by medical home physicians and 350,015 patients treated by primary care physicians not in medical homes. The analysis looked at quality measures and utilization metrics.[16] HealthCore is currently comparing the medical homes' performance over time against that of the control practices.

Methodological limitations include lack of severity adjustment and failure to consider particular market dynamics that may have been responsible for variation. For example, in the Colorado pilot, utilization of medical services in the base period, the twelve months before implementation, was higher than the state average. Patient-centered medical home inpatient admissions and emergency department visits in the period after implementation declined to levels that were closer to the state averages, but this decline could have reflected natural variation.

Besides the lack of risk adjustment, results are based on medical claims only and thus do not take pharmacy claims into account. Success of the New Hampshire patient-centered medical home is being analyzed in more detail to assess drivers of quality performance, utilization, and costs.

When using claims data in a study focused on quality, there is a risk that there may be miscoding and that incomplete data may be used. Furthermore, although the comparison group of patients attributed to a non–medical home practice was limited to patients in the same geographic area, the evaluators did not adjust for potential sociodemographic differences between the populations.[15]

Finally, it is possible that the non–medical home practices may have been engaging in ad hoc quality improvement efforts. However, we were not aware of any such efforts that were either systematic or targeted at achieving National Committee for Quality Assurance recognition as a medical home.[15]

Study Results

Preliminary results of the analysis conducted by WellPoint's affiliated health plan on its members in the Colorado pilot[17] showed an 18 percent decrease in acute inpatient admissions per thou-

sand over the study period, compared with an 18 percent increase in the control group (see Appendix Exhibit 1a).[13] The analysis also showed a 15 percent decrease in total emergency department visits per thousand, compared with a 4 percent increase in the control group.

Specialty visits per thousand among the patient-centered medical home patients in Colorado remained flat, compared with a 10 percent increase in the control group. For every dollar that WellPoint invested, the estimated return on investment during the study period ranged from 2.5:1 to 4.5:1. There was improvement on all measures of diabetes care (see Appendix Exhibit 2a).[13]

In addition, patient satisfaction was high, as measured by HealthTeamWorks' compilation of patient survey data. Ninety-five percent of the survey respondents said that the care setting was well organized and efficient, and 97 percent said they would recommend it to their family or friends. Ninety percent of the respondents said it was easy to speak to a physician when they called their medical home practice.

In the New Hampshire pilot, preliminary all-payer results based on fifteen months of data showed the following trends:[18] For those in the medical home, the per patient per month cost declined from the "pre" to the "post" period, while the cost increased in the control group. Quality results were unchanged. The patient-centered medical home cohort had a greater decline in its emergency department visit rate over the study period than did the control group. The New Hampshire pilot had a positive impact on utilization of health care services in the first year. For WellPoint's health plan participants, costs increased 5 percent in the patient-centered medical home, compared to 12 percent in traditional practices. Although quality data are currently being analyzed, quality performance does not appear to have been adversely affected.[19]

The baseline data for the New York pilot showed that the enrollees in the patient-centered medical home practices had better compliance with evidence-based and preventive health care guidelines, lower utilization rates, and lower costs than the patients in the control practices. For instance, patients with diabetes had higher rates of hemoglobin A1c testing in the patient-centered medical home practices than in the control practices (82.1 percent versus 77.7 percent).[15]

Rates of inappropriate use of antibiotics for pediatric patients were also lower in the patient-centered medical home practices compared to the control practices (27.5 percent versus 35.4 percent). Likewise, patients in the patient-centered medical home had fewer emergency department visits than patients in the control practices (11 percent fewer for adults and 17 percent fewer for children).[15]

Finally, the risk-adjusted total per patient per month costs for the patient-centered medical home population were lower than the costs for patients in the control population (14.5 percent lower for adults, 8.6 percent lower for children).[15] For more details on the outcomes of the New York pilot, see the online Appendix.[13]

Patient-Centered Primary Care Strategy

Payment innovation through these three pilots demonstrated preliminary evidence of improvement in the quality and affordability of care. As a result, after initial evaluation of the pilots, WellPoint created its Patient-Centered Primary Care strategy to expand the reach of concepts relating to the patient-centered medical home to primary care practices that are run along more traditional lines.

Starting in 2012, WellPoint's affiliated health plans and the primary care physicians throughout its fourteen-state network entered into contracts designed to improve the quality of care and lower costs. The intent is to bring widespread transformation to all WellPoint-affiliated health plans' markets and primary care physicians, encouraging a commitment to enhanced collaboration, care coordination, patient-centeredness, and the adoption of health information technology and information sharing. WellPoint believes that broad physician participation in patient-centered primary care will have a favorable impact on population health and health care costs.

Patient-centered care in this broader context must address the needs of a variety of stakeholders. For example, patients want accessible care focused on their personal situations. Physicians want to be rewarded for providing higher-quality and more affordable care. As with medical homes, components required for success are structuring payment and providing resources to support more comprehensive care.

WellPoint's affiliated health plans will partner with physicians on several key elements. First, to support population health management and care planning, the plans will provide physicians with useful health information pulled from claims data and enriched with lab results.

Second, care managers and nurses on the plans' staffs will work closely with practices to improve care coordination. This integrated care management model will encourage physicians to engage their patients in care that emphasizes prevention and optimizes health.

Third, WellPoint is hiring additional nurses and other health professionals to support physicians in practice transformation. These professionals will help analyze data; plan and coordinate care; and develop interventions aimed at reaching worthy goals, such as the reduction of inappropriate emergency department use. Ongoing evaluation will ensure that collaborative efforts produce the quality results that WellPoint's health plans, physicians, and—most important—patients are seeking. WellPoint will continuously assess quality of care and patient satisfaction against national performance measures and evaluate the impact of utilization measures, such as emergency department use, that drive costs.

This strategy will shift primary care reimbursement from a volume-based model, in which physicians are paid only for patient encounters, to a value-based model that rewards quality and efficiency and compensates doctors for clinical interventions that occur outside a traditional office visit. Over time, the program will issue value-based payments that will supplement traditional fee-for-service payments and compensate physicians for a range of non-visit-based services, such as maintaining disease registries, developing care plans for patients with chronic conditions, creating comprehensive postacute transition plans, communicating with patients by e-mail, and helping patients navigate the complexities of the health care system.

In addition, physicians who meet or exceed the quality metrics set by WellPoint-affiliated health plans will be eligible to receive a portion of the savings if the cost of care for their defined population is less than targeted levels.

For physicians who are willing to take on greater accountability and risk, the revenue opportunities will be more significant. For small physician groups that do not have enough patients to establish statistically meaningful cost targets, WellPoint intends to create virtual groups by aggregating the data from members across practices into statistically valid risk pools. These virtual groups will also function as learning communities, sharing best practices on transforming care delivery. This effort will help establish statistical validity while creating a community that is driving quality improvement. The program will also be available to primary care doctors affiliated with or employed by large integrated delivery systems who want to improve health outcomes and affordability for their patients. These larger groups may not require aggregation.

Furthermore, physicians will be required to achieve a quality threshold to receive any shared savings, regardless of financial performance. The better a physician performs against nationally recognized quality metrics, the more shared savings that physician will be entitled to receive.

WellPoint believes that engaging physicians through patient-centered primary care will help reduce waste; increase resource efficiency; improve compliance with evidence-based guidelines; improve patient outcomes; and decrease avoidable admissions, readmissions, and emergency department visits. In so doing, WellPoint's expanded strategy should help practices achieve the first two prongs of the "Triple Aim": improved quality and lower costs.[20] At the same time, by enhancing access and promoting shared decision making with patients, the strategy should advance the third aim: improved patient experience.

Conclusion

WellPoint's mission is to improve the lives of the people we serve and the health of our communities. The fundamental changes in primary care that we have described are essential for this mission. Key elements for success are better quality, improved access to physicians, and enabling the exchange of clinical information to improve patient care.

WellPoint recognizes that models to improve primary care are likely to evolve. Opportunities are growing for telemedicine, after-hours access in retail settings, and the involvement of other health professionals in care teams. Payment models that encourage such practices are scalable and can encourage the patient-centered care that is needed to transform the US health care system. ■

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NOTES

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12 This was the WellPoint health plan rate. Other payers' rates ranged from $4 to $8 per member per month.
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In this month's *Health Affairs*, Ruth Raskas and colleagues, all now or previously with WellPoint, report on several of the ten patient-centered medical home pilots that the insurer has backed in various locations around the country. Full evaluations are ongoing, but preliminary assessments are that the pilots are meeting some cost, utilization, and quality objectives—enough so that WellPoint is applying similar payment strategies to primary care practices that may not have the resources to become full-fledged medical homes.

Raskas is vice president of clinical health policy at WellPoint, where she works with industry and academic leaders and national health policy organizations to shape policies aimed at improving health care quality, safety, and affordability. She is chief of staff for WellPoint's chief medical officer, working in this capacity with network providers and care management teams to advance public health and medical outcomes.

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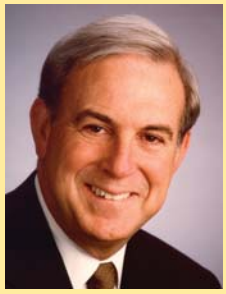

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